

Fearrington Plastic Surgery / Patient Information Sheet

Account: _____ Date: _____

Patient

Last Name: _____ First Name: _____ M.I.: _____
Street Address: _____ Apartment/Suite: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ SS#: _____
Date of birth: _____ Age: _____
Driver's license no.: _____ Exp. Date: _____ State: _____
Work related injury? Yes No Auto or other accident? _____
Employer: _____
Street Address: _____ Suite: _____
City: _____ State: _____ Zip: _____
Occupation/type of work: _____
Spouse's name: _____ Spouse's Employer: _____
Address: _____ Phone no.: _____
Friend/relative (not living with you): _____
Relationship: _____ Phone no.: _____
Referred by: _____ Referring physician: _____
Personal physician: _____ Phone no.: _____

Insurance Information

Company Name: _____
Address: _____ Effective date: _____
Subscriber no.: _____ Policy no.: _____ Group no.: _____
Secondary Carrier: _____ Subscriber no.: _____ Group no.: _____
Name of Insured (as it appears on card): _____

Guarantor Information

Please complete the section below if *someone other than the patient* is responsible for the bill.

Name: _____ Street Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Relationship to patient: _____ Occupation: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____
Business phone: _____

Payment is required at time of service unless prior arrangements have been made. Please indicate preferred method of payment:

Cash Check Credit Card (VISA/MasterCard)

Your signature below indicates your consent for treatment of/as patient and responsibility for paying the bill. I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

Signature: _____ Date: _____

I hereby authorize the payment of medical benefits directly to the physician.

Signature: _____ Date: _____